

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Country Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W Pearl St Pomona, CA 91768	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924</p> <p>Based on interview and record review, the facility failed to ensure the resident's dignity was maintained for one of four sampled residents (Resident 4).</p> <p>This failure violated Resident 4's right to be treated with dignity and respect which could affect Resident 4's physical, mental, and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was readmitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) following other intracranial hemorrhage (bleeding within the skull), functional quadriplegia (the complete inability to move due to severe disability or frailty), and noninfective gastroenteritis and colitis (inflammation of your stomach, intestines).</p> <p>During a review of Resident 4's History & Physical (H&P), dated 2/6/24, the H&P indicated, Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 4's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 4/5/24, the MDS indicated, Resident 4 had moderate cognitive (processes of thinking and reasoning) impairment, was dependent on staff for showering and bathing self, and frequently incontinent of bowel and bladder.</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated, Resident 2 was readmitted to the facility on [DATE], with diagnoses that included hemiplegia (muscle weakness or partial paralysis on one side), essential hypertension (high blood pressure without identifiable cause), and epilepsy (brain nerve cell activity is disturbed).</p> <p>A review of Resident 2's History & Physical (H&P), dated 8/3/23, the H&P indicated, Resident 2 had the capacity to understand and make decisions.</p> <p>A review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 was cognitively intact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/15/24 at 2:55 p.m. with Resident 4, Resident 4 stated that Certified Nurse Assistant (CNA) 4 did not clean Resident 4 well, and CNA 4 only cleaned Resident 4's front. Resident 4 stated CNA 4 would pull off Resident 4's covers and CNA 4 would point CNA 4's finger at Resident 4. Resident 4 stated CNA 4 would tell Resident 4 to stop yelling because people were sleeping. Resident 4 stated CNA 4 did not change Resident 4 and left Resident 4 soiled. Resident 4 stated CNA 4 made Resident 4 feel awful and made Resident 4 feel angry when CNA 4 did not clean Resident 4 well.</p> <p>During an interview on 7/15/24 at 4:40 p.m. with Resident 2, Resident 2 stated Resident 2 heard CNA 4 yell at Resident 4 that Resident 4 was not wet (unable to recall date and time of incident).</p> <p>During an interview on 7/15/24 at 4:49 p.m. with the Director of Nursing (DON), the DON stated staff must not raise the staff voice at the residents. The DON stated raising voice towards the residents could cause emotional issues and the resident could feel disrespected.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity, revised 12/19/ 22, the P&P indicated, the facility protected and promoted resident rights and treated each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintained or enhanced resident's quality of life by recognizing each resident's individuality. The P&P indicated, all staff members involved in providing care to residents promoted and maintained resident dignity and respected resident rights. The P&P indicated, staff members spoke respectfully to residents and avoided discussions about residents that may be overheard.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light for one of four sampled residents (Resident 4) was within reach.</p> <p>This deficient practice had the potential to result in the delay of care for Resident 4 when Resident 4 was unable to reach Resident 4's call light to call staff for assistance.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the AR indicated, Resident 4 was readmitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) following other intracranial hemorrhage (bleeding within the skull), functional quadriplegia (the complete inability to move due to severe disability or frailty), and noninfective gastroenteritis (inflammation from an infection in your stomach and intestines) and colitis (inflammation of the large intestine).</p> <p>During a review of Resident 4's History & Physical (H&P), dated 2/6/24, the H&P indicated, Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 4's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 4/5/24, the MDS indicated, Resident 4 had moderate cognitive (processes of thinking and reasoning) impairment.</p> <p>During an interview on 7/15/24 at 12:45 p.m. with Resident 4, Resident 4 stated Resident 4 did not know where Resident 4's call light was. Resident 4 stated Resident 4 yelled for help because Resident 4 could not find Resident 4's call light. Resident 4 stated due to a mobility issue, Resident 4 could reach her call light with Resident 4's left hand. Resident 4 stated the staff placed Resident 4's call light on her left side which Resident 4 stated Resident 4 was unable to move.</p> <p>During a concurrent observation and interview on 7/15/24 at 12:52 p.m. with Certified Nurse Assistant (CNA) 3, Resident 4's call light was on the floor and behind Resident 4's bed. CNA 3 stated Resident 4's call light should not be behind Resident 4's bed. CNA 3 stated the previous CNA could have brought Resident 4's food tray and left Resident 4's call light there (on the floor and behind Resident 4's bed). CNA 3 stated Resident 4 was unable to reach Resident 4's call light behind Resident 4's bed. CNA 3 stated it was important for the call light to be within Resident 4's reach so that Resident 4 could call staff if she needed something or in an event of an emergency.</p> <p>During an interview on 7/15/24 at 4:49 p.m. with the Director of Nursing, the DON stated keeping the call light within resident's reach was important for resident to get staff attention when resident needed assistance from staff. The DON stated a resident might try to get up, even though not necessary, and yell or call out for help when the call light was behind the bed, on the floor, and not within reach.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 12/19/22, the P&P indicated, staff was educated on the proper use of the resident call system, including how the system works, and ensuring resident access to the call light. The P&P indicated, the call system was accessible to residents while in bed or other sleeping accommodations within the resident's rooms.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>36924</p> <p>Based on observation, interview and record review, the facility failed to maintain a homelike environment by failing to ensure two of two shower rooms in the facility were kept clean.</p> <p>This failure had the potential to result in an unsanitary environment for the residents.</p> <p>Findings:</p> <p>During an observation on 7/13/24 at 4:58 p.m., the resident shower room located in Skilled Nursing Facility 1 (SNF 1) had chipped paint on the tile located inside the shower stall and had black colored substance in the far-right corner of the shower stall.</p> <p>During a concurrent observation of the resident shower room located in SNF 1 and an interview with Maintenance Supervisor (MS) on 7/13/24 at 6:00 p.m., MS observed the peeling paint on the shower tiles inside the shower room. MS observed black colored substance between the wall tiles and in the corner of the shower, and between the grout on the gray floor tiles inside the shower room. MS stated the colored substance was black and dirty and MS described the black colored substance as dirt build up. MS stated he missed the chipping paint on the shower tiles and MS stated he needed to repair the chipping paint on the tiles. MS stated housekeeping was responsible for cleaning the resident shower rooms.</p> <p>During a concurrent observation and interview on 7/15/24 at 1:17 p.m., with the Housekeeping Supervisor (HS), the HS stated the HS observed the black substance inside the corners and between tiles in SNF 1 shower room. HS stated HS also observed a black substance in the Subacute (SA) shower room. During a concurrent observation with the HS of the SA shower room, a black substance was observed in the grout between the tiles and in the corners of shower. HS stated it was housekeeping department 's responsibility to clean the showers. HS stated the black substance should not be in the shower. HS did not state what the black substance was.</p> <p>During an interview on 7/15/24 at 1:20 p.m. with the MS, the MS stated the black substance found inside the SNF shower room indicated the shower was not cleaned properly.</p> <p>During a review of the facility's Policy & Procedure (P&P), titled, Safe & Homelike Environment, revised December 2022, the P&P indicated the facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.</p>		